Community Service Network 2 Meeting
Dorothea Dix, Bangor, Maine
September 9, 2008

DRAFT Minutes

Members Present:

- Annette Adams, Acadia
- Melinda Davis, AIN
- Brent Bailey, Allies Inc.
- Catherine Holloway, Assistance Plus
- Theresa Oliver, Bangor Counseling Center
- Michelle St. Louis, Behavioral Health Center
- Beth Brown, Care & Comfort
- Richard Brown, Charlotte White Center
- Dale Hamilton, CHCS
- David McCluskey, Community Care
- Jill Peters, Dirigo Counseling
- Susan Buck, Fellowship Health Resources
- Lydia Richard, Maine Mental Health Connections & Together Place
- John Spieker, Mayo Regional Hospital
- Sue Rouleau, MDI Behavioral Health
- Betty Foley, Medical Care Development
- Gayla Dwyer, MMC Voc, Emp. Coordinator
- Sheryl Bowen, MMC Employment Spec, CSN 2
- Joanne Marian, NAMI-ME Families
- Jenni Howard, NFI North
- Charles Tingley, NOE
- Kathy Smith, OHI
- Michael Corbin, Penobscot Valley Hospital
- Barbara Kerrigan, Phoenix Mental Health
- Sharon Dean, Sunrise Opportunities
- Sharon Tomah, Wabanaki-Sweetser
- Corey Schwinn, WCPA

Members Absent:

- Blue Hill Memorial Hospital
- CA Dean Memorial Hospital
- Calais Regional Hospital
- Consumer Council System of Maine
- Down East Community Hospital
- Families United
- Maine Coast Memorial Hospital
- Millinocket Regional Hospital
- Regional Medical Center at Lubec
- St. Joseph's Hospital
- Wings

Alternates/Others Present:

- Judy Provencher, Medical Care Development
- Linda Keil Wakely, Psychologist (private practice)
- Vicki Karlsson, LCPC (private practice)

Staff Present: DHHS/OAMHS: Sue Lauritano, Mary Louise McEwen, Don Chamberlain, Marya Faust, Scott Kilcollins, Leticia Huttman. Muskie School: Elaine Ecker.

Agenda Item	Discussion
I. Welcome and Introductions	Sue opened the meeting and participants introduced themselves.
II. Review and Approval of Minutes	The minutes from the August meeting were approved as written.
III. Feedback on OAMHS Communications	Sue asked members if they had any feedback on OAMHS communications over the past month. One member asked OAMHS to clarify the process for requesting a waiver of requirements re: grant-funded services. The initial communication on APS and Grant Funds did not spell this out. <u>Communication process change/clarification</u>: Members were informed that all communications from OAMHS, whether statewide or regional, will go to the CSN representatives with the expectation that information will be shared within that representative's organization as necessary. All communications will also be posted on the CSN website. OAMHS is concerned that all information gets to staff who need to know.
IV. Legislative Session January 2009 – Suggested Bills	Marya explained that during September, OAMHS files topics for legislation. At this point in the process, OAMHS has put forward several concepts without specific language for the DHHS Commissioner and Governor to consider: 1. <u>Prior authorization for PNMI beds</u>: MaineCare does not allow for prior authorization for PNMI beds, and this

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	requires legislative authority to change the MaineCare rule. 2. Add forensic patients to the bill authorizing clinical review panels to mandate involuntary medications: At this time, only those civilly committed come under the provisions of this bill. OAMHS would like legislation to include people on the forensic side as well. 3. Expansion of CNA Registry to include other direct care workers: Presently, there is no registry for people working in the mental health field with MHRT certifications and therefore no way to track or record the performance of those working in the field. OAMHS would like to expand the current CNA registry to include direct support mental health professionals (MHRT/C, MHRT/I, MHSS) as a way of assuring knowledge and quality of who is practicing. Also, once a person is certified there is now no mechanism to decertify. This would provide that. 4. Exempt critical incident reporting from discovery and expand and clarify the mandate for reporting. 5. Reduction and disposal of unused medications (two concepts, for safety and less waste): a. Shorten new medication prescriptions to 14 days, with no co-pays: Finding the most effective medications often requires trials and can result in waste and disposal issues if abandoned prescriptions have been written for the usual 60-90 day period. Under this concept, any new prescription would be written for a shorter period and consumers would not be liable for co-pay on any of them, even if it involves several trials. b. Establish authority of Department of Public Safety (DPS) re: disposal of unused drugs, rather than the Department of Environmental Protection (DEP). DHHS and DPS want to remove disposal of unused drugs from DEP regulations and establish new regulations. DHHS and DPS see drugs as different from other hazardous materials. Discussion: • Does 14-day prescription proposal cover all drugs in the MaineCare formulary and everyone with medication benefits? A: Yes. Response: Good, it's nice to include everyone on new medications. Providers often have to "climb the latter of rule-outs" before certain drugs can be prescribed. • Doctors would have to change their practice to write 14-day prescriptions… A: Yes, and perhaps it will end up being a 30-day supply, but that would still make a substantial difference. • On clinical review panel legislation, would rather see that repealed than made to include forensic patients. How are you going to education the community? A: OAMHS' role and those of community providers and consumers may differ—stakeholders will have to get together and work these things out. • Will clarifying the "lay person" terminology be addressed? A: Yes. • Might the Registry be expanded to include other direct care workers, Developmental Disabilities, Elders? A: Yes, it is a broader issue than just mental health. Ombudsman • Melinda of AIN proposed that OAMHS initiate legislation establishing an Ombudsman for the Office of Adult Mental Health Services. In view of constant change of laws it is more necessary than ever, she said, noting the OAMHS is the only category in DHHS that doesn't have an ombudsman. She explained that an ombudsman will work on consumers' behalf when no one else is doing so and expanded on this using the bill with forced medication as an example. The "lay person" (designated in the bill) is an employee of the hospital. No one from outside that arena helps the consumer talk about options or speaks on the consumer's behalf. • Marya said it sounded more like an advocate role (fights for), rather than her understanding of an ombudsman role (negotiator). She said there is no language in the bill for an advocate, though there have

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	been thoughts about adding. A motion to add the establishment of an Ombudsman to OAMHS' legislative agenda was made and seconded, but failed to pass. <u>Non-categorical coverage – eligibility for grant funds</u> • Chuck Tingley of NOE proposed major changes in non-categorical MaineCare coverage, including the elimination of that level of coverage altogether. Marya explained the purpose of establishing non-categorical coverage initially, and Don asked several questions in an effort to clarify this discussion. The resulting understanding: Propose legislation to increase available dollars, cap, or benefits (e.g. CI services) for MaineCare non-categorical coverage. • Don reiterated OAMHS' continuing efforts to define the population for which services must be publicly provided, for class members and for non-class members, especially in light of shrinking grant/general dollars. Negotiations continue with the Court Master, et al., on this matter. • A member brought up the use of grant funds to continue services for those in "spend-down," noting the disproportionate nature of this issue. People lose services and go into crisis. • There's a population that's being excluded and people served previously that won't be eligible. • Are you not worried you're nudging toward a two-tier system? A: That's what we've been working not to have. "<u>24-Hour Rule</u>" Don initiated a discussion of an issue that arose at the Hospital/Class meeting in Region III—what to do if the process of involuntary commitment is not completed within the allowable 24-hour period? Don said the Assistant Attorney General gave an opinion in a recent meeting, but the language is not yet clear or established: To reevaluate in the hospital to determine if person still meets involuntary status, and if so, start 24-hour clock over. Members expressed concerns and reticence about starting the 24-hour period over again, noting it may remove the urgency, it doesn't feel right to remove people's rights in that manner, and it may have other unintended consequences. In response to an idea that smaller increments of time be added, i.e. 4 hours, a member conveyed doubts that such a short time would make any real difference in resolving difficult placements. Annette Adams suggested looking at Massachusetts language around this issue for guidance. Don asked if members wanted OAMHS to put in a legislative 'placeholder' on this issue. Members made and passed the following motion: **MOTION:** That OAMHS initiate legislation to better define what would happen when the 24-hour involuntary commitment period expires before placement is accomplished. **ACTION:** OAMHS will come back with language for legislation next month for CSN consideration/decision on whether to support that language. <u>CSN Purpose</u> At this point, a member stated his concern over an issue that has never been resolved: The role of the CSNs. When the Department wants CSN support, then CSN recommendations are accepted. When the CSN disagrees or proposes otherwise, the input is not considered. We're expected to be here, and the Department can say, "We may or may not

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	take your advice." But if we're not here, it affects our contracts. There's a fundamental issue that needs to be resolved. The purpose was to find new ways to provide services, and that has been lost. What **is** the role and relationships of people attending? Another member applauded the courage to raise this issue and agreed that it needs to be resolved. <u>APS Healthcare Administrative Burden</u> Two private therapists visited the CSN meeting in order to let OAMHS know the effect of the heavy burden the APS process puts on private practitioners who don't have the time or resources to 1) complete the extensive paperwork involved in authorizations, and 2) to dispute with APS about those they may initially deny. They informed that a large number of private practitioners are forming a group to address these issues. They would like to be able to resolve them in a helpful way, so they can continue to provide services. Some have or are considering discontinuing services for MaineCare clients. When clients face the prospect of having to make complaints or advocate for continued therapy with APS, they often terminate their services rather than fight and risk losing what they have. MaineCare reimbursements are also very far behind, and the two issues pose serious problems for providers. CSN member providers also strenuously expressed the difficulties they are having with APS processes, approvals, and most troublesome, being denied reimbursement based on technicalities or unavoidably missed deadlines—even when clinical need turned out not to be in question. Members gave examples of burdensome or negative protocols, overwhelming administrative mandates, and significant problems with Care Connection, APS' online system. • 14-page reauthorization "nightmare." • Claims lost or suspended in the system. • Unrealistic limits on units/hours of service, e.g. 8 hours for outpatient therapy: "No one will start with a chronic person that takes a long time to resolve, if only get 8 or 16 hours." • "Case managers are scrambling," now having to do two mental health assessments. • "I was kicked off the system 14 times trying to enter one person." Marya and Don indicated this was the first they were hearing of some of these problems. A member took issue with that saying their agency has had nothing but problems from day one and had many, many conversations with APS and with OAMHS. "The Department needs to choose whether to support APS or providers and consumers," he said, expressing strongly that "we're not being <u>heard</u>." The system has changed from cooperative to adversarial, and there's no one to go to address problems. Marya and Don clarified that they have heard about administrative burden issues, but not about non-payments. "Early on," the member shared, "there was a lot of forgiveness [with APS process], if the service was needed. At some point in time, there was no more forgiveness." Members advised that the Department should have an APS quality committee and should use its contractual authority to hold APS accountable for paying claims. The situation could become untenable for providers unless the Department steps in and takes directive action. The long discussion concluded with the following formal recommendation being made and passed:

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	RECOMMENDATION: That the Department create a quality review process for the ASO system that meets monthly, possibly represented by CSN members, driven by the Department.
V. Budget	Don and Marya opened the discussion regarding the budget process (Supplemental 2009, Biennial 2010-2011). Though OAMHS has submitted their initial budget requests, the Commissioner knows additional requests are being gathered through the CSNs in September. Don mentioned the budget template OAMHS sent out in August for members' use, and asked for any proposals members may have prepared for consideration. Two detailed proposals were shared with the group: <u>Maine Mental Health Connections</u> Maine Mental Health Connections made two budget requests and also submitted a petition: 1) $45,000 to hire staff to enable the Together Place to meet growing needs in its peer programs; 2) $7,500 to cover expected increases in heating costs for Community Connections, Together Place Social Club, and Together Place Housing; 3) petition with 121 signatures calling for an investigation into the inequitable distribution of funds for peer services and the development of a new system of distribution. <u>Advocacy Initiative Network (AIN)</u> Melinda described a proposal for expansion and delivery of the Wellness and Recovery Action Plan (WRAP) program. She explained that WRAP done correctly meets a broad number of consumer needs and continuity of care issues. The program has never been utilized as it could be, and beyond the initial costs, WRAP is a billable Section 17 service. She explained further that AIN would be the provider agency with its own clinician and would train three sets of peers in each CSN. She estimated it would take six months to do that and the next six months they would actually be doing WRAPs. The initial costs/contract would be $200,000 and the next contract would require no funding, since the program would sustain itself. After each presentation above, Don asked members to vote on whether they supported the proposal. Members voiced reluctance to vote for several reasons: • Outside of the context of the whole budget, don't think the CSN should go on record. Voting on concepts to meet services, yes… • Agree the CSN is a vehicle for specific areas, but not comfortable voting on specific programs or agencies. Support an increase of peer services, for example, but that level of detail is too much. • Hesitate to respond to one idea over another, knowing the funds are limited and someone will get "pinched." Members should not be in that position. Don listed the following items re: OAMHS' budget requests: • Large increase in BRAP (Bridging Rental Assistance Program) funds. • Four additional employment specialists. • If definition of target population is broadened [in negotiations re: Consent Decree], we will need more funds for a variety of services. Continuing budget discussion: • We're scared; we've been hurt—not used to being asked, "What do you need?" We just want to survive. • There was a time when case managers and clinicians, for example, had more flexibility to spend time with

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	consumers. If we're going to survive in this business, we have to look at what's on the fringe that can be done without. Reimbursing the core services in a way that we can meet other needs is crucial. • We need to focus on data-driven outcomes and evidence-based practices to attract dollars to us. • Richard Brown briefly reviewed the history of deinstitutionalization and the fact that most communities were not ready for it. One result has been significant increases in numbers of people with mental illnesses in the criminal justice system. It's a growing problem. Where can we intervene? How do we get in early to divert people from being sentenced? This issue is very important, but largely ignored as far as budget issues. • At what point does the Commissioner for this Department advocate for the needs of the people served? A: She works for the Governor and must operate within those parameters. • The budget can't be balanced on the backs of the most vulnerable. • Perhaps the State can consider paying its bills? Recommend that be considered in this budget process.
VI. Public Comments on Budget	Will Ron [Welch] see this as completing his obligation for input on the budget?—I hope not.
VII. Consumer Council Update	The Council's representative was not present to report.
VIII. Report from the Employment Services Network (ESN)	No time for this item.
IX. Impact of Energy Costs	No time for discussion of this item, beyond brief mention by Don about context of requesting data around expected increases in heating and travel costs. Additional funds for fuel for PNMIs has already been included in OAMHS budget.
X. Wraparound Funds	Sue distributed copies of the wraparound funds policy. This item will appear for discussion on the next agenda.
XI. Other	None.
XII. Public Comment	None.
XIII. Meeting Recap and Agenda for Next Meeting	See **ACTION** items above. October Meeting Agenda: OAMHS Communication Legislative--Bills, Budget, including language re: "24-hour rule" Consumer Council Update Employment Specialist and ESN Updates Subcommittee Reports, including review of Transformation Subcommittee Report Wraparound Funds